AMBULANCE AUTHORIZATION FORM FOR MEDICAID

Beneficiary's Name: _____ **Date of Transport:** ____/____/____

Medicaid I.D. Number: _____

_____ Ambulance Service, Basic Life Support, Non-Emergency Transport (BLS) – (Procedure Code A0428)
(A DHEC licensed ambulance vehicle with staff and equipment on board that provides treatment in basic life support situations.)

I understand that Medicaid will only cover transport to Medicaid-sponsored services in accordance with the following age limitations. This recipient is being transported to and from the following Medicaid service:

From

___ R-Residence
___ H-Hospital
___ N-Nursing Home
___ P-Physician Office
___ G-Hospital-Based Dialysis
___ J-Non-Hospital-Based Dialysis
___ Adult Residential Facility
___ Unlisted/Other -- **Provide complete address and telephone number below**:

_____
_____
_____

To

___ P-Physician Office
___ H-Hospital
___ N-Nursing Home
___ G-Hospital-Based Dialysis
___ J-Non-Hospital-Based Dialysis
___ 076 (Duplicate procedure, same day of service)
___ Emergency Vision Care (to age 21)
___ Preventive and Restorative Dental Care (to age 21)
___ Emergency Dental Care (over age 21)
___ Adult Day Health Care

Check all that apply:

☐ Need to suction airway
☐ Contractures
☐ Non-healed fractures
☐ Special Handling en route – Isolation
☐ Moderate to severe pain on movement
☐ Danger to self or others – monitoring
☐ Confused, combative, lethargic, comatose
☐ DVT requires elevation of a lower extremity
☐ I.V. medications/fluids required during transport
☐ Danger to self or others – seclusion (flight risk)
☐ Cardiac/Hemodynamic monitoring required during transport
☐ Morbid Obesity requires additional personnel/equipment to handle
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Third party assistance/attendant required to apply, administer, or regulate
☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit
☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
☐ Other: Please specify current medical condition requiring transport: _____

_____

I certify that it is medically necessary for this patient to be transported by ambulance. Transportation by any other means could be detrimental and medically inadvisable. This certification is provided within my professional scope of practice and applicable state law.

_____ (**Signature of Requestor, Title**) **Date**: _____/_____/_____
(Attending physician, physician assistant, nurse practitioner, clinical nurse specialist or registered nurse)

_____ (**Print Name of Requestor, Title)**

_____ (Facility Name) County: _____

Vehicle odometer reading (To): _____ Vehicle odometer reading (From): _____

(**A DHEC Run Report must be attached to DHHS Form 216 when submitting a claim for reimbursement.**)